Management of urinary incontinence in women

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NICE’s guideline on the management of urinary incontinence in women has now been expanded to include pelvic organ prolapse. This article provides an overview of the latest guidance.

NICE first published a clinical guideline on the management of urinary incontinence in women in 2006. It updated this in 2013 and has now revised it once more, expanding it somewhat to Urinary Incontinence and Pelvic Organ Prolapse in Women: Management (NG123).¹

The new guideline excludes previous advice on the use of synthetic polypropylene or biological mesh insertion for women with recurrent anterior vaginal wall prolapse following recognition of severe and debilitating complications, referring the reader to its separate recommendations on transvaginal mesh repair of anterior or posterior vaginal wall prolapse (IPG599, December 2017).²

The guideline has been extensively updated. It recommends that specialist services should be delivered through multidisciplinary teams (MDTs) at local (for women with primary stress urinary incontinence, overactive bladder or primary prolapse) and regional (for complex pelvic floor dysfunction and mesh-related problems) levels. MDTs should work within a clinical network to facilitate referral. Acknowledging public concern about the complications of mesh insertion, NICE now recommends collecting data for a national registry, stating unusually strongly that clinicians ‘must ensure’ this is carried out and specifying the information that should be gathered.

Non-surgical management of urinary incontinence now includes a trial of supervised pelvic floor muscle training of at least three months’ duration as first-line treatment for women with stress or mixed urinary incontinence. Absorbent containment products, hand-held urinals and toileting aids should be offered only as a coping strategy pending definitive treatment, as an adjunct to ongoing therapy, or for long-term management of urinary incontinence only after treatment options have been explored. Their use should be reviewed at least annually by a trained health professional.
Overactive bladder

Changes to the recommendations covering medication for overactive bladder affect mainly the information and advice that should be offered to women. Before starting treatment, women should be told about the likely effectiveness of medication, its adverse effects, that the onset of effect may take up to four weeks, and that the long-term impact on cognitive function is uncertain. The choice of treatment should take into account co-morbidity such as poor bladder emptying, cognitive impairment or dementia, the use of other medicines with anticholinergic activity, and the risk of adverse effects – particularly cognitive impairment. NICE did not review evidence of effectiveness for this update but calls for research to clarify the balance of efficacy and safety. The 2018 guideline on dementia (NG97) provides more advice on medicines that may cause cognitive impairment.

Drug-specific advice is largely unchanged: flavoxate, propantheline or imipramine are not recommended for urinary incontinence or overactive bladder, and immediate-release oxybutynin should not be prescribed for women at risk of a sudden deterioration in their physical or mental health. Otherwise, the product of choice is the least expensive option. GPs should review women who remain on long-term medication for overactive bladder or urinary incontinence every 12 months, or every six months if they are aged over 75 years.

Changes to recommendations on invasive procedures for overactive bladder largely affect the use of botulinum toxin type A (Botox), which should be offered if non-surgical management and medication are unsuccessful. The initial dose should be 100 units, subsequently increasing to 200 units if necessary. NICE acknowledges that there is limited evidence about the long-term effects of this approach. The first follow-up appointment should take place 12 weeks after the injection (previously it was six months).

Stress incontinence and pelvic organ prolapse

The remainder of the guideline includes extensive updates and additions to recommendations on surgical management of stress urinary incontinence and the assessment and management of pelvic organ prolapse. NICE notes the true prevalence of long-term complications of surgery for stress incontinence is not known and recommends its decision aid for women considering this option. The guideline lists several procedures that should not be offered, but provides guidance on the use of colposuspension, autologous rectus fascial sling, intramural bulking agents, mid-urethral mesh sling procedures and (as a last resort) artificial urinary sphincter. If a woman chooses a procedure not provided by the consulting surgeon, she should be referred to another surgeon. The importance of gathering data for a national registry is emphasised again.

Management options for pelvic organ prolapse should take into account individual preferences, age, lifestyle factors, the wish to have children, co-morbidity and surgical history. Women should avoid heavy lifting, and constipation should be treated or prevented. Topical oestrogen may be appropriate for women with signs of vaginal atrophy. Pelvic floor training should be offered to women with stage 1 or 2 pelvic organ prolapse, alone or in combination with a pessary (supported by information about complications).

Surgical options should be considered with the support of a decision aid, in particular discussing the pros and cons of different procedures, the risk of recurrence, uncertainty about long-term effects, and the hospital stay and recovery periods associated with each procedure. Finally, NICE offers detailed advice on the assessment and management of complications associated with mesh surgery, including local vaginal effects and impact on urinary and bowel function.

References


Declaration of interests

None to declare.

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